

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4983AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER DARLINGTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 339 EMDEN ST. HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a bed increase and annual State licensure survey conducted at your facility on November 7, 2008.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed for 7 beds, Residential Facility for Groups which provides care to individuals who are elderly and disabled and have mental illness, Category II residents.</p> <p>The facility has applied to receive a two-bed increase and has been approved to provide care for nine residents at this time.</p> <p>The census was 7. Seven resident files and two employee files were reviewed.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>There were no regulatory deficiencies identified at the time of the survey. Please retain this copy for your records.</p>	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE